For Office Use Only:

D.J. Jacobetti Home for Veterans

Department of Military & Veterans Affairs

APPLICATION FOR ADMISSION

425 Fisher Street
Marquette, MI 49855
Phone: (906)226-3576
Toll Free: (800)433-6760
Fax: (906) 226-2380

(Please Print)

Today's Date:	Filing Status:	☐ Veteran	☐ Non-veteran

APPLICANT INFORMATION

Applicant's last name:	First:	Middle:	Place of Birth:

Is this your legal name?		If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:	
☐ Yes	☐ No					☐ M	☐ F

Street address:	City:	State:	ZIP Code

County of Residence:	Telephone #:
	( )

Social Security #:	Religious Preference:	Marital status:
		Single ☐ Mar ☐ Div ☐ Sep ☐ Widowed ☐

If previously married or divorced, provide the information below:

Date of Marriage:	Spouse Name:	Birthdate:	Social Security #:	Date of Death or Divorce:

RESPONSIBLE PARTY/EMERGENCY CONTACT INFORMATION

(The responsible party will receive the monthly statement. If applicant, state "Self")

Responsible Party Name:	Relationship to Applicant:		E-Mail Address:
Street Address:	City:	State:	Zip Code:
Home phone #: ( )	Work phone #: ( )		Cell phone #: ( )
Emergency Contact Name:	Relationship to Applicant:		E-Mail Address:
Street Address:	City:	State:	Zip Code:
Home phone #: ( )	Work phone #: ( )		Cell phone #: ( )
Secondary Contact Name:	Relationship to Applicant:		E-Mail Address:
Street Address:	City:	State:	Zip Code:
Home phone #: ( )	Work phone #: ( )		Cell phone #: ( )
Third Contact Name (if applicable):	Relationship to Applicant:		E-Mail Address:
Street Address:	City:	State:	Zip Code:
Home phone #: ( )	Work phone #: ( )		Cell phone #: ( )

FUNERAL ARRANGEMENTS

Funeral Home Preference:	Address:	City, State:	Phone no.:
			( )

Cemetery Preference:	City, State:

INSURANCE INFORMATION

(Include copies of all insurance cards – front & back- with your application)

Medicare Eligible? If yes, -→ ☐ Yes ☐ No	☐ Part A (Hospital): Effective Date:	☐ Part B (Medical): Effective Date:

Medicare Part D (prescription) Coverage? If yes, -→ ☐ Yes ☐ No	Company Name:	Rx Group #:	Rx PCN #:
		ID#:	Rx Bin #:

Former/Current Occupation:	Former Employer:	Former Employer address:	If Retired, last date worked:

Is the applicant covered by other health insurance?	☐ Yes	☐ No	Please indicate primary Insurance name:	

Subscriber's name:	Contract ID:	Group Number:	Prescription Coverage: ☐ Yes ☐ No Co-Pay:

Is the applicant covered by dental insurance?	☐ Yes ☐ No	If yes, insurance name:	Policy Number:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Other	

Medicaid Eligible? If yes -→ ☐ Yes ☐ No	Card Number:	Case Number:	County:

MILITARY INFORMATION

(The original or certified copy of the Veteran's Discharge or DD-214 or other document must accompany this application)

Branch of Service:	Wars Served in:	Type of Discharge:	Date of Entry into Active Duty:
☐ Air Force ☐ Army ☐ Coast Guard ☐ Marines ☐ Navy	☐ WW2 ☐ Korean ☐ Cold War ☐ Vietnam ☐ Gulf ☐ Iraqi Freedom	☐ Honorable ☐ Medical ☐ Retirement ☐ General (under honorable conditions)	Date of Separation:

Service Serial Number:	Place of Entry:	Place of Separation:

VETERAN'S ADMINISTRATION INFORMATION

VA Claim Number (if applicable):	Service Connected Disability? ☐ Yes ☐ No	If yes, state disability(ies) and percent:

Did a veterans service organization assist you with your claim: ☐ Yes ☐ No	If yes, name of organization: (e.g. VFW, Amer. Legion, DAV, etc.

MISCELLANEOUS INFORMATION

Have you ever been convicted of a felony: ☐ No ☐ Yes If yes, list all arrests & convictions:

Charge:	Date:
Charge:	Date:

FINANCIAL INFORMATION

		Amount	Please List Source
APPLICANT MONTHLY INCOME	Income 1		
	Income 2		
	Income 3		
	Total Monthly Income		
SPOUSE'S MONTHLY INCOME	Income 1		
	Income 2		
	Income 3		
	Total Monthly Income		

STATEMENT OF ASSETS (estimate value)	**APPLICANT**	**APPLICANT'S SPOUSE IF APPLICABLE**
Home or Other Real Estate		
Other Real Estate		
Other Property		
Vehicle #1		
Vehicle #2		
Bank Account(s)		
Investment		
Other Investment		
Stocks, Bonds, IRA's		

STATEMENT OF LIABILITIES		
Mortgage		
Outstanding Debt #1		
Outstanding Debt #2		

TRANSFERS

Have you sold, transferred, or created a joint tenancy (ownership) in any property within the last 36 months? (This includes cash and bank accounts)

Applicant: ☐ Yes ☐ No Applicant's Spouse: ☐ Yes ☐ No

If yes, to (or with) whom:

Date of Transaction: **In What Amount:**

PLEASE REVIEW YOUR APPLICATION TO MAKE CERTAIN THAT IT IS ACCURATE BEFORE YOU PLACE YOUR SIGNATURE ON THIS NOTARIED DOCUMENT

I, , being first duly sworn, depose and state that the foregoing questions have been carefully read (by me) or (to me), and that the answers I have given to the same are true to the best of my knowledge and belief. I fully understand and agree that, if I am admitted to the Home, I must abide by the laws of the State of Michigan pertaining to the Home and the rules and regulations of the Home.

Applicant/Guardian signature		*Date*

Subscribed and sworn to before me this

_____ day of _____, 20_____.

State of Michigan, County of _____

My Commission Expires: _____

_____
Notary Public

MEDICAL INFORMATION

Name:

Date:

Major Diagnoses:

Allergies:

Smoker? ☐ YES ☐ NO

Disabilities:
☐ Amputation ☐ Paralysis
☐ Contracture ☐ Decubiti

Impairments:
☐ Speech ☐ Hearing
☐ Vision ☐ Sensation

Activity Tolerance Limitations: ☐ None ☐ Moderate ☐ Severe

Mental Alertness:
☐ Alert ☐ Forgetful ☐ Confused ☐ Occasion. Confused

Test: Date:

Chest x-ray

Lab Work

Immunizations: (Dates)

Tetanus:

Influenza:

Pneumonia:

TB Skin Test:

Diet:

Special Diet:

Restrictions:

Swallowing Problems:

Medications:

Treatments:

Bed:
Low Bed: ☐ Yes ☐ No
Mattress: ☐ Regular ☐ Firm
☐ Specialty

Oxygen Therapy:
☐ Yes ☐ No

Prognosis:

Independent	*Needs Assistance*	*Unable To Do*	Check level of self-care ability:
☐	☐	☐	Bathing
☐	☐	☐	Shaving
☐	☐	☐	Oral Hygiene
☐	☐	☐	Bladder Program
☐	☐	☐	Bowel Program
☐	☐	☐	Dressing Lower Extremities
☐	☐	☐	Dressing Upper Extremities
☐	☐	☐	Feeding
☐	☐	☐	Sitting
☐	☐	☐	Standing
☐	☐	☐	Stairs
☐	☐	☐	Walking # of Feet
☐	☐	☐	Wheelchair

Communication Ability:
☐ Can Speak
☐ Can Write
☐ Understands Speaking
☐ Understands Gestures
☐ Understands Writing

Appliances:
☐ Eyeglasses
☐ Dentures
☐ Hearing Aid(s)
☐ Prosthesis
☐ Crutches
☐ Cane
☐ Walker
☐ Wheelchair

Signature of Doctor or Nurse completing form: